

**Texas Department of Insurance, Division of Workers' Compensation**

Medical Fee Dispute Resolution, MS-48

7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1609

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION**PART I: GENERAL INFORMATION**

Requestor's Name and Address:

EDWARD J BRANDECKER MD
1888 ANTILLEY RD
ABILENE TX 79606

MFDR Tracking #:

M4-04-5794-01

Respondent Name and Box #:

Liberty Insurance Corp.
Box #: 28**PART II: REQUESTOR'S POSITION SUMMARY AND PRINCIPLE DOCUMENTATION**

Requestor's Position Summary: "Dr. Brandecker is requesting that this case please be reviewed and for our office to be reimbursed fairly for services that have been rendered in the amount of \$855.23"... "Enclosed are several EOBS with letters that show reimbursement from other carriers where the facility fees have been paid almost double of what Liberty Mutual is calling reasonable. Included are the denials/reductions from Liberty Mutual, medical documentation the actual claims, examples and redacted information or payment our facility has received from other TWCC carriers. TWCC 60, and letters that were sent in our defense to Senator Troy Fraser." [sic]

Principle Documentation:

1. DWC 60 Package
2. Total Amount Sought - \$855.23
3. Hospital Bill
4. EOB
5. Medical Records

PART III: RESPONDENT'S POSITION SUMMARY AND PRINCIPLE DOCUMENTATION

Respondent's Position Summary: "Liberty Mutual has adopted the basic ASC methodology utilized by CMS for Medicare reimbursement of services delivered in ASCs. This methodology was selected after much research because: It is very well established and uniform, is based upon the highly respected capability of Medicare and their extensive data research, the data is public, the CPT codes have been identified as to the appropriate payment group, and this methodology is used by many group health insurers and managed care plans as the basis for payment and / or contract negotiation. Also per the TX fee schedule, if these procedures were performed in the inpatient setting the hospital would be reimbursed at the rate of \$1118.00 for the one day, including an overnight stay. These or similar payment rates are therefore considered 'fair and reasonable'..." Using the current (Oct. 2002) Medicare ASC group rates, Liberty Mutual chose to reimburse the facilities at 200% of the Medicare rate."... "The methodology is documented and consistently applied to all ambulatory surgery services in Texas."

Principle Documentation:

1. Response Package

PART IV: SUMMARY OF FINDINGS

Date(s) of Service	Denial Code(s)	Disputed Service	Amount in Dispute	Amount Due
9/15/2003	Z601, Z652, X094	Outpatient Surgery	\$855.23	\$0.00
Total Due:				\$0.00

PART V: REVIEW OF SUMMARY, METHODOLOGY AND EXPLANATION

Texas Labor Code §413.011(a-d), titled *Reimbursement Policies and Guidelines*, and Division rule at 28 Texas Administrative Code §134.1, titled *Use of the Fee Guidelines*, effective May 16, 2002 set out the reimbursement guidelines.

1. For the services involved in this dispute, the respondent reduced or denied payment with reason code:
 - Z601 – “The charge exceeds usual and customary.”
 - Z652 – “Recommendation of payment has been based on a procedure code which best describes services rendered.”
 - X094 – “Charges included in the facility fee.”
2. This dispute relates to outpatient surgical services provided in an ambulatory surgical center with reimbursement subject to the provisions of Division rule at 28 TAC §134.1, effective May 16, 2002, 27 TexReg 4047, which requires that “reimbursement for services not identified in an established fee guideline shall be reimbursed at fair and reasonable rates as described in the Texas Workers’ Compensation Act, §413.011”...
3. Texas Labor Code §413.011(d) requires that fee guidelines must be fair and reasonable and designed to ensure the quality of medical care and to achieve effective medical cost control. The guidelines may not provide for payment of a fee in excess of the fee charged for similar treatment of an injured individual of an equivalent standard of living and paid by that individual or by someone acting on that individual’s behalf. It further requires that the Division consider the increased security of payment afforded by the Act in establishing the fee guidelines.
4. Division Rule at 28 TAC §133.307(e)(2)(B), effective January 2, 2002, 26 TexReg 10934; amended to be effective January 1, 2003, 27 TexReg 12282, applicable to disputes filed on or after January 1, 2003, requires that the request shall include “a copy of each explanation of benefits (EOB)”... “relevant to the fee dispute or, if no EOB was received, convincing evidence of carrier receipt of the provider request for an EOB”. This request for medical fee dispute resolution was received by the Division on January 27, 2004. Review of the documentation submitted by the requestor finds that the request does not include a copy of each explanation of benefits relevant to the fee dispute. Neither has the requestor submitted convincing evidence of carrier receipt of the provider request for an EOB. The Division concludes that the requestor has failed to submit the request in the form, format and manner prescribed by the Division sufficient to meet the requirements of 28 TAC §133.307(e)(2)(B).
5. Division rule at 28 TAC §133.307(g)(3)(C), effective January 2, 2002, 26 TexReg 10934; amended to be effective January 1, 2003, 27 TexReg 12282; and applicable to disputes filed on or after January 1, 2003 requires the requestor to send additional documentation relevant to the fee dispute including “a statement of the disputed issue(s) that shall include: (i) a description of the healthcare for which payment is in dispute, (ii) the requestor’s reasoning for why the disputed fees should be paid or refunded, (iii) how the Texas Labor Code and commission [now the Division] rules, and fee guidelines, impact the disputed fee issues, and (iv) how the submitted documentation supports the requestor position for each disputed fee issue. This request for medical fee dispute resolution was received by the Division on January 27, 2004. Pursuant to §133.307(g)(3), the Division notified the requestor on February 3, 2004 to send the additional required documentation. Review of the submitted documentation finds that the requestor did not state how the Texas Labor Code and Division rules impact the disputed fee issues. The Division concludes that the requestor has not provided documentation sufficient to meet the requirements of Division rule at 28 TAC §133.307(g)(3)(C)(iii).
6. Division Rule at 28 TAC §133.307(g)(3)(D), effective January 2, 2002, 26 TexReg 10934; amended to be effective January 1, 2003, 27 TexReg 12282, applicable to disputes filed on or after January 1, 2003, requires the requestor to provide “documentation that discusses, demonstrates, and justifies that the payment amount being sought is a fair and reasonable rate of reimbursement”... The requestor’s position statement does not articulate a methodology under which fair and reasonable reimbursement should be calculated. The requestor’s *Table of Disputed Services* indicates that payment is sought in the amount of the billed charges less the amount previously paid by the insurance carrier. The requestor’s position statement asserts that “Enclosed are several EOBS with letters that show reimbursement from other carriers where the facility fees have been paid almost double of what Liberty Mutual is calling reasonable. Included are the denials/reductions from Liberty Mutual, medical documentation the actual claims, examples and redacted information or payment our facility has received from other TWCC carriers.” [sic] However, review of the submitted documentation finds that the requestor has not submitted any redacted EOBS for review.
7. Review of the submitted documentation finds that the requestor has provided one redacted settlement agreement for payment of services in the amount of \$1,003.50; however, the settlement agreement does not detail the services that were paid and it cannot be determined from the submitted evidence whether the services that are the subject of the redacted settlement agreement are the same or similar to the services in dispute.
8. Further review of the requestor’s documentation finds that the requestor does not explain how it determined that payment of \$855.23 would result in a fair and reasonable reimbursement for the services in dispute. The requestor does not discuss or explain how payment of the requested amount would ensure the quality of medical care, achieve effective medical cost control, ensure that similar procedures provided in similar circumstances receive similar reimbursement, or otherwise satisfy the statutory requirements and Division rules.

9. Additionally, a reimbursement methodology based upon payment of the hospital's billed charges, or a percentage of billed charges, does not produce an acceptable payment amount. This methodology was considered and rejected by the Division in the *Acute Care Inpatient Hospital Fee Guideline* adoption preamble which states at 22 *Texas Register* 6276 (July 4, 1997) that "A discount from billed charges was another method of reimbursement which was considered. Again, this method was found unacceptable because it leaves the ultimate reimbursement in the control of the hospital, thus defeating the statutory objective of effective cost control and the statutory standard not to pay more than for similar treatment of an injured individual of an equivalent standard of living. It also provides no incentive to contain medical costs, would be administratively burdensome for the Commission and system participants, and would require additional Commission resources." Thorough review of the documentation submitted by the requestor finds that the requestor has not discussed, demonstrated or justified that payment of the amount sought would be a fair and reasonable rate of reimbursement for the services in dispute. Additional reimbursement cannot be recommended.
10. The Division would like to emphasize that individual medical fee dispute outcomes rely upon the evidence presented by the requestor and respondent during dispute resolution, and the thorough review and consideration of that evidence. After thorough review and consideration of all the evidence presented by the parties to this dispute, it is determined that the submitted documentation does not support the reimbursement amount sought by the requestor. The Division concludes that this dispute was not filed in the form and manner prescribed under Division rules at 28 Texas Administrative Code §133.307(e)(2)(B), §133.307(g)(3)(C)(iii) and §133.307(g)(3)(D). The Division further concludes that the requestor failed to meet its burden of proof to support its position that additional reimbursement is due. As a result, the amount ordered is \$0.00.

PART VI: GENERAL PAYMENT POLICIES/REFERENCES

Texas Labor Code § 413.011(a-d), § 413.031 and § 413.0311
28 Texas Administrative Code §133.307, §134.1
Texas Government Code, Chapter 2001, Subchapter G

PART VII: DIVISION DECISION AND/OR ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the Requestor is not entitled to additional reimbursement for the services involved in this dispute.

DECISION:

Authorized Signature

Medical Fee Dispute Resolution Officer

Date

VIII: YOUR RIGHT TO REQUEST AN APPEAL

Either party to this medical fee dispute has a right to request an appeal. A request for hearing must be in writing and it must be received by the DWC Chief Clerk of Proceedings within **20** (twenty) days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. **Please include a copy of the Medical Fee Dispute Resolution Findings and Decision** together with other required information specified in Division Rule 148.3(c).

Under Texas Labor Code Section 413.0311, your appeal will be handled by a Division hearing under Title 28 Texas Administrative Code Chapter 142 Rules if the total amount sought does not exceed \$2,000. If the total amount sought exceeds \$2,000, a hearing will be conducted by the State Office of Administrative Hearings under Texas Labor Code Section 413.031.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.